

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038994

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1235

FILED NOV 6 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph,		c. CITY OR TOWN Chillicothe,	
Length of stay in lb 10 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Meth. Hosp. & Med. Center		d. STREET ADDRESS (If outside, give location) 220 Woodrow Street	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ARTHUR GIBBONS		4. DATE OF DEATH Month Day Year October 29, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1908
9. AGE (last birthday) 55	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Churchill Truck Lines Livingston Co., Mo.
10c. CITIZEN OF WHAT COUNTRY U.S.A.		11. BIRTHPLACE (City and state or country)	
13a. FATHER'S NAME Charles Gibbons		13b. MOTHER'S MAIDEN NAME Mable Krouse	
14. NAME OF HUSBAND OR WIFE Ruth Gibbons		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of dates of service) Yes W. W. # 2	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ruth Gibbons-Chillicothe, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Embolism (R) Sudden</i> DUE TO (b) <i>Multiple Traumatic Injuries -</i> DUE TO (c) <i>Multiple Fract Ribs - Fract Vertebrae</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal Bigger condition given in Part I (a) <i>Multiple Fract Ribs - Fract Vertebrae</i> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION St. Joseph, Mo.		20g. COUNTY Livingston	
20h. STATE Missouri		20i. DATE Oct 15-63 to Oct 29, 1963	
21. I attended the deceased from <i>Oct 15-63</i> to <i>Oct 29, 1963</i> and last saw him alive on <i>Oct 29, 1963</i> Death occurred at <i>6:45 PM</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert W. Kieber, M.D.</i>		22b. ADDRESS <i>St. Joseph, Mo.</i>	
22c. DATE SIGNED <i>10-31-63</i>		23a. BURIAL CREMATION, REMOVAL (Specify) Burial	
23b. DATE Nov. 2, 1963		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Memorial Gardens	
23d. LOCATION (City, town, or county) Chillicothe, Missouri		23e. REGISTRAR'S SIGNATURE <i>Mrs. Clark Stoddell</i>	
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.			
25. DATE RECD. BY LOCAL REG. Nov. 5, 1963			

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DATE AMENDED

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1 5117
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10-30-63

NOV 12 1963

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Permit issued 10-30-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert B. Harrington

Licensed Embalmer No. 3268

P. O. Address St Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.